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	175338	A. BUILDING _____ B. WING _____	05/15/2015

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey and investigation of complaint #84863. An amended 2567 sent on 5/20/15.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility

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written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents. Based on record review and staff interview, the facility failed to notify 1 (#71) resident in advance of changes in his/her services and failed to provide a copy of the Notice of Medicare Provider Non-provider Coverage for 1 resident (#77) .

Findings included:

- Review of the information provided for resident #71 revealed the facility terminated the services effective 12/17/2014. The Notice of Medicare Provider Non-Coverage form (CMS 10123) revealed the form was signed on 12/08/2014, one day after the services were terminated.

The facility was unable to locate the Notice of Medicare Non-Coverage (form CMS-10123) for resident
#77.

During an interview on 05/12/2015 at 4:36 P.M. administrative nursing staff E stated he/she was unable to locate additional information for resident #71 regarding when the paperwork was given to the resident or verify a staff member spoke with the resident before the due date.

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F 156	Continued From page 3 An interview on 05/12/2015 at 4:33 with administrative staff A stated he/she was unable to locate the Notice of Medicare Non-Coverage paperwork in their file for resident #77. The facility failed to provide the appeal notice informing resident #71 and #77 of his/her rights to a review prior to his/her Medicare services being terminated.	F 156		
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents with a sample size of 20 residents. Based on observation, interview, and record review, the facility failed to have resident access to the use of a telephone where calls were made without being overheard for 1 (#53) of 2 residents sampled for privacy. Findings included: - Resident #53's Quarterly Minimum Data Set (MDS) dated 3/22/15 revealed a Brief Interview	F 174		

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for Mental Status (BIMS) of 15 indicating intact cognition.

The care plan dated 2/20/15 for depression listed the resident had a long history of depression, and he/she would structure his/her own leisure time.

In an interview on 5/11/2015 at 11:43 A.M. he/she stated the facility did not provide privacy for his/her phone calls.

Observation on 5/12/15 at 1:30 P.M. resident sitting in his/her room in a wheelchair.

On 5/12/15 at 1:30 P.M. he/she stated he/she did not have privacy when talking on the phone. When he/she went to the nurse's station for a phone call, it was not private due to the nurses sat at the desk, he/she was not aware there was a portable phone that could come to his/her room.

On 5/12/15 at 1:40 P.M. the resident asked administrative staff A if there was a phone to use in his/her room. Administrative staff A stated the portable phone was available for use in the resident rooms but when it went in the rooms the phone had increased static and it was difficult to hear on. Administrative staff A further stated if a resident needed privacy they could come into any of the offices and use the phone in there.

On 5/13/15 at 2:45 P.M. direct care staff Q stated when a resident received a phone call on the cordless phone, he/she placed the resident by the fire place in the common area, the cordless phone did not reach to the resident rooms. If a call would come in on the nurse's station phone

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F 174	Continued From page 5 the resident would need to take the call at the nurse's station. Review of the facility policy for Telephone Privacy dated 10/1/07 revealed it was the policy of the center to honor each resident's right to have privacy, at any reasonable hour to a telephone where he or she may speak privately. Each resident will be provided, upon their request with access to a telephone (and assistance with its use) that is private. The facility failed to have equipment and space available to the resident that ensured the resident could hear the speaker and not be overheard.	F 174		
F 223 SS=G	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: The facility had a census of 55 residents. The sample included 20 residents. Based upon observation, record review and interview the facility failed to maintain a safe environment free from potential abuse for residents when staff refused to provide care for two residents (#12 #82) causing fear for the resident's to ask for assistance and required residents to wait for toileting causing incontinent episodes. The	F 223		

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facility failed to protect the Resident #12 from physical abuse when there was an allegation of rough treatment and the Resident sustained an abrasion and bruising.

Findings included:

- Resident #12's quarterly MDS dated 03/01/2015 revealed the resident scored 9 (moderate impaired cognition) on the Brief Interview for Mental Status, did have delusions, hallucinations or behaviors, and was occasionally incontinent of urine.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/02/2014 revealed the resident had a diagnosis of dementia and required extensive staff assistance with bed mobility, transfers and toileting. The CAA included the resident was incontinence of urine throughout the day and would void appropriately at times when toileted.

The resident's care dated 11/25/15 and revised 3/6/15 included staff approached the resident warmly and positively at all times and provided consistent caregivers to the extent possible.

Review of a concern/grievance report dated 12/16/14 documented the resident stated that on the night shift 12/15/14 into 12/16/14, he/she turned on his/her call light because he/she needed to use the bathroom. Licensed nurse L answered the resident's call light and told the resident he/she would be right back. The resident waited about 30 minutes and then re-activated his/her call light. Licensed nurse L came back and still did not take the resident to

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the bathroom. Licensed nurse L told the resident that he/she did not need 2 pillows and licensed nurse L "ripped" the pillow out from under the resident and the pillow scraped the resident's forehead. Licensed nurse L left the room and the resident turned his/her call light back on because he/she still needed to use the restroom. The resident stated another nurse came into the room and stated he/she would inform licensed nurse L. The resident stated he/she ended up waiting so long that he/she was forced to "pee" in his/her pants. When licensed L reentered the resident's room, licensed nurse L made the resident stay in bed while he/she changed the resident and licensed nurse L was rough when turning the resident and the resident's right hip was hurt. The resident informed licensed nurse L his/her right hip hurt from him/her pushing on it and licensed told the resident he/she would have a nurse get him/her a pain pill. The form included the social service designee observed a small red scrape on the upper left side of the resident's forehead.

Review of the facility's investigation dated 12/17/14 documented the resident stated licensed nurse L made him/her wait for 30 minutes and would not toilet him/her. Licensed nurse L ripped a pillow out from under the resident's head and the resident sustained a scrape on his/her left forehead. When licensed nurse L changed the resident because he/she was soiled the resident stated licensed nurse L was rough with him/her while turning her and hurt his/her hip when he/she pushed on it.

The investigation included administrative nursing staff E interviewed the resident and noted an abrasion on the left side of the resident's

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forehead approximately 4 centimeters in length. Administrative nursing staff E also noted three small fingertip size bruises on the resident's right hip.

On 5/12/15 at 3:45 P.M. the resident sat in a chair in his/her room and related the incident to the surveyor. The resident became tearful when he/she spoke of soiling his/her pant. The resident stated during the incident he/she did not say anything to licensed nurse L because he/she feared it would make the situation worse. The resident showed the surveyor a picture of him/her with the abrasion sustained during the incident on night shift of 12/15/14 into 12/16/14. Observation revealed a prominent area on the resident's left forehead that appeared as a gash/abrasion that measured approximately 3 centimeters.

On 5/13/15 at 9:20 A.M. administrative staff A stated the resident was upset by the incident and could still recall the incident.

The facility failed to ensure Resident #12 had an environment free of abuse and fear when staff refused to assist the resident with care and caused resident to be fearful.

- Resident #82's May 2015 Physician Order Sheet identified the resident was admitted to the facility on 5/4/15 with a diagnosis of retention of urine.

A Minimum Data Set was not completed.

The resident's temporary plan of care dated 5/5/15 included the resident required assistance of 2 staff for toileting and repositioning. The temporary care plan included the resident was always incontinent of urine. The care plan did not

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include a toileting program/schedule for the resident.

On 5/11/15 at 11:41 A.M. during Stage 1 of the survey the resident stated staff did not treat him/her with dignity and respect. The resident stated his/her physician had told him/her to go to the bathroom every hour. The resident stated over the weekend he/she asked licensed nurse L to assist him/her to the bathroom and licensed nurse L stated "never mind you just wait". The resident stated she also asked licensed nurse L to put powder on an area he/she had under his/her breast and licensed nurse stated he/she would do it when he/she got around to it. The resident stated he/she expressed the concern to administrative staff.

On 5/12/15 at approximately 4:45 P.M. a staff stated the resident informed him/her on 5/11/15 that licensed nurse L refused to take him/her to the bathroom and also refused to place powder under his/her breast. The staff he/she related the concern to administration.

On 5/13/15 at 9:15 A.M. administrative staff A stated he/she was aware of the concern. He/she also stated the facility had received other concerns in the past regarding licensed nurse L.

Resident #82's May 2015 Physician Order Sheet identified the resident was admitted to the facility on 5/4/15 with a diagnosis of retention of urine.

A Minimum Data Set was not completed.

The resident's temporary plan of care dated 5/5/15 included the resident required assistance

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F 223	Continued From page 10 of 2 staff for toileting and repositioning. The temporary care plan included the resident was always incontinent of urine. The care plan did not include a toileting program/schedule for the resident. On 5/11/15 at 11:41 A.M. during Stage 1 of the survey the resident stated staff did not treat him/her with dignity and respect. The resident stated his/her physician had told him/her to go to the bathroom every hour. The resident stated over the weekend he/she asked licensed nurse L to assist him/her to the bathroom and licensed nurse L stated "never mind you just wait". The resident stated she also asked licensed nurse L to put powder on an area he/she had under his/her breast and licensed nurse stated he/she would do it when he/she got around to it. The resident stated he/she expressed the concern to administrative staff. On 5/12/15 at approximately 4:45 P.M. a staff stated the resident informed him/her on 5/11/15 that licensed nurse L refused to take him/her to the bathroom and also refused to place powder under his/her breast. The staff he/she related the concern to administration. On 5/13/15 at 9:15 A.M. administrative staff A stated he/she was aware of the concern. He/she also stated the facility had received other concerns in the past regarding licensed nurse L. The facility failed to ensure Resident #82 had a safe environment free from abuse when staff refused to assist the resident with care making the Resident wait for toileting.	F 223		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		

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F 225 SS=D	Continued From page 11 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		

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This REQUIREMENT is not met as evidenced by:
The facility had a census of 55 residents. Based upon observation, record review and interview the facility failed to report 2 (#12, #47) allegations of abuse to the state licensing and survey agency.

- Review of a concern/grievance report dated 12/16/14 documented that resident #13 stated that on the night shift 12/15/14 into 12/16/14, he/she turned on his/her call light because he/she needed to to the bathroom. Licensed nurse L answered the resident's call light and told the resident he/she would be right back. The resident waited about 30 minutes and then put his/her call light on again. Licensed nurse L came back and still did not take the resident to the bathroom. Licensed nurse L told the resident that he/she did not need 2 pillows and Licensed nurse "ripped" the pillow out from under the resident and the pillow scraped the resident's forehead. Licensed nurse L left the room so the resident turned his/her light back on because he/she still needed to use the restroom. The resident stated another nurse came into the room and stated he/she would inform licensed nurse L. The resident stated he/she ended up waiting so long that he/she was forced to "pee" in his/her pants. When licensed L reentered the resident's room, licensed nurse L made the resident stay in bed while he/she changed the resident and licensed nurse L was rough when turning the resident and the resident's right hip got hurt. The resident informed licensed nurse L his/her right hip hurt from him/her pushing on it and licensed told the resident he/she would have a nurse get him/her a pain pill. The form included the social service designee observed a small red scrape on

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the upper left side of the resident's forehead.

Review of the facility's investigation dated 12/17/14 documented the resident stated licensed nurse L made him/her wait for 30 minutes and not not toilet him/her. Licensed nurse L ripped a pillow out from under the resident's had and the resident's sustained scrape on his/her left forehead. When licensed nurse L changed the resident because he/she was soiled the resident stated licensed nurse L was rough with him/her while turning her and hurt his/her hip when he/she pushed on it.

The investigation included administrative nursing staff E interviewed the resident and noted an abrasion on the left side of the resident's forehead approximately 4 centimeters in length. Administrative nursing staff E also noted three small "finger tip" size bruises on the resident's right hip. During the investigation Staff L was suspended. The facility replaced all pillows that may have been the cause of the abrasion.

On 5/12/15 at 3:45 P.M. the resident showed the surveyor a picture of him/her with the abrasion sustained during the incident on night shift of 12/15/14 into 12/16/14. Observation revealed a prominent area on the resident's left forehead that appeared as a gash/abrasion that measured approximately 3 centimeters.

On 5/13/15 at 9:20 A.M. administrative staff A stated the incident was reported by the resident as abuse and the facility did not report the allegation of abuse to the state licensing and survey agency.

The facility's Abuse Prevention Policy and

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Procedure revised 1/25/15 included alleged violations and substantiated incidents were reported to the state agency immediately.

The facility failed to report the allegation of abuse to the state licensing and survey agency.
- The quarterly Minimum Data Set (MDS) dated 4/12/15 for resident #47 revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. He/she required extensive assistance from 1 staff member for walking in the corridor, locomotion on the unit, toilet use, and bathing. He/she was always incontinent of bladder and bowel.

The 8/8/14 Care Area Assessment (CAA) regarding activities of daily living (ADLs) revealed the resident required total assistance with toileting and incontinence cares.

The care plan with a revision date of 4/17/15 revealed the resident had a history of depression and staff were to provide him/her with an environment that was calm and non-stressful. He/she required assistance from staff for grooming and personal hygiene.

Observation on 5/13/15 at 7:20 A.M. revealed the resident rested in bed with his/her eyes closed.

Interview on 5/11/15 at 10:53 A.M. with the resident revealed he/she had experienced verbal abuse from a staff member. He/she reported on or around 5/9/15 an aide on the day shift was in his/her room after he/she had been incontinent of urine which had saturated the bed and leaked onto the floor. The staff member told the resident to get his/her "butt off the bed." The resident said the staff member was frequently rude to him/her

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and did not think the staff member treated him/her with respect and dignity.

On 5/11/15 at approximately 5:00 P.M. 2 members of the survey team informed administrative staff A about the situation of the resident reporting abuse during an interview. The surveyors explained which resident reported and what he/she said. Staff A verbalized understanding.

Interview on 5/12/15 at 4:35 P.M. with the resident revealed the same story and timeframe from the previous interview.

On 5/13/15 at 8:00 A.M. the survey team checked with the regional office and found that the facility had not reported the incident to the state agency.

Interview on 5/13/15 at 10:50 A.M. with direct care staff O revealed if he/she observed a staff member being verbally inappropriate to a resident he/she would report it to the nurse.

Interview on 5/13/15 at 11:06 A.M. with licensed nursing staff I revealed if he/she received a report of abuse he/she would notify the administrator and/or director of nursing immediately and expected all allegations to be reported to the state.

Interview on 5/13/15 at 2:31 P.M. with licensed nursing staff J revealed if any type of abuse was reported to him/her then he/she would notify the administration. Staff J stated if nothing was done then he/she would report it to the state.

Interview on 5/13/15 at 1:50 P.M. with administrative staff A revealed he/she was aware

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F 225	Continued From page 16 of the incident involving the resident and a staff member. He/she reported he/she spoke with the resident after being made aware of the situation from the survey team and the resident told him/her the staff member was frequently rude to him/her and other residents. Staff A stated he/she did not report it to the state because he/she did not feel it rose to the level of verbal abuse. Interview on 5/13/15 at 3:33 P.M. with administrative nursing staff D revealed he/she expected all allegations of abuse to be reported to the state and for all staff to treat the resident's with respect and dignity. The policy provided by the facility with a revision date of 1/25/15 regarding abuse prevention revealed alleged violations and substantiated incidents were reported to the state agency immediately. The facility failed to report this resident's allegation of verbal abuse to the state agency in a timely manner.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility had a census of 55 residents. Based upon record review and interview the facility failed	F 226		

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F 226	Continued From page 17 to include the requirements in accordance with the Federal Justice Act. Findings included: - Review of the facility's Reporting Abuse to State Agencies and Other Entities/Individuals Policy and Procedure revised 1/25/15 did not include requirements in accordance with the Federal Justice Act. The policy did not include reporting suspicious crimes to law enforcement within 2 hours . The policy did not include the reporting requirement of each staff member or a statement that an employee could file a complaint with the state survey agency against a long-term care facility without retaliation. On 5/13/15 at approximately 11:30 A.M. administrative staff A confirmed the facility's policy and procedure did not address the requirements of the Elder Justice Act. The facility failed to develop policies and procedures in accordance with the Elder Justice Act.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: The facility had a census of 55 residents. The sample included 20 residents. Based upon	F 241		

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observation, record review and interview the facility failed to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality for 2 (#47, #67) of 4 residents.

Findings included:
- Resident #67's Quarterly Minimum Data Set (MDS) dated 3/8/15 listed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition.

The care plan dated 3/13/15 listed the resident was new to the facility and moved here out of state within the last year. Staff should encourage the resident to visit with friends and family and schedule treatments and therapies around visitors. Staff should visit with the resident to allow him/her to talk about his/her feelings.

On 5/11/2015 at 10:53 A.M. the resident stated he/she went to get help for his/her spouse about a month ago and the nurse told him/ her to get back in his/her room if someone was available they would be there.

On 5/12/15 at 10:00A.M. the resident sat in his/her room in the wheelchair.

On 5/12/15 at 2:45 P.M. The resident stated he/she remembered talking about the incident when he/she went to get help for his/she spouse about a month ago and the nurse toldhim/her to get back in his/her room if someone was available they would be there. He/she cannot recall the exact date of the incident, only that it was day shift staff, the resident stated he/she saw the person who said that a few days ago but

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could not see the name tag.

On 5/12/15 at 3:01 P.M. interview with the resident's family member stated the resident told him/her about the incident a while ago, he/she could not recall the exact date the resident talked to family about it, but the incident was reported to administrative nursing staff D.

On 5/12/15 at 4:55 P.M. administrative nursing D stated family of the resident did inform him/her of the incident, he/she talked with the resident but since the resident could not identify the staff member involved he/she did not document or do an investigation of the occurrence. Administrative nursing staff D further stated the resident felt he/she was scolded as if he/she were a child.

Review of the medical record revealed no documentation to support administrative nursing staff D addressed the residents concern. There was no documentation to support administrative staff D attempted to identify the staff or investigate the incident.

On 5/13/15 at 1:30 P.M. direct care staff V stated to treat a resident with dignity was to be respectful of the resident ' s privacy, come to eye level when speaking to them, and not treat them like children.

Review of the facility policy for Dignity Rounds dated revised 3/30/07 listed the purpose of rounds was to focus on observation of dignity issues are a "best practice" to assure consistent practices that enhance resident quality of life.

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The facility failed to insure staff interacted in a manner that enhanced self-esteem and self-worth for this resident.

- The quarterly Minimum Data Set (MDS) dated 4/12/15 for resident #47 revealed a Brief Interview for Mental Status (BIMS) score of 7, indicating severe cognitive impairment. He/she required extensive assistance from 1 staff member for walking in the corridor, locomotion on the unit, toilet use, and bathing. He/she was always incontinent of bladder and bowel. The resident received 7 doses of an antidepressant (a medication used for the treatment of depression; abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness and emptiness) and 7 doses of a diuretic (medication to promote the formation and excretion of urine).

The 8/8/14 Care Area Assessment (CAA) regarding activities of daily living (ADLs) revealed the resident required total assistance with toileting and incontinence cares.

The care plan with a revision date of 4/17/15 revealed the resident had a history of depression and staff were to provide him/her with an environment that was calm and non-stressful. He/she required assistance from staff for grooming and personal hygiene.

Observation on 5/13/15 at 7:20 A.M. revealed the resident rested in bed with his/her eyes closed.

Interview on 5/11/15 at 10:53 A.M. with the resident revealed he/she had experienced verbal abuse from a staff member. He/she reported on or around 5/9/15 an aide on the day shift was in

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his/her room after he/she had been incontinent of urine which had saturated the bed and leaked onto the floor. The staff member told the resident to get his/her "butt off the bed". The resident said the staff member was frequently rude to him/her and did not think the staff member treated him/her with respect and dignity.

On 5/11/15 at approximately 5:00 P.M. 2 members of the survey team informed administratative staff A about the situation of the resident reporting abuse during an interview. The surveyors explained which resident reported and what he/she said. The administrator verbalized understanding.

Interview on 5/12/15 at 4:35 P.M. with the resident revealed the same story and timeframe from the previous interview. The resident identified the staff member as direct care staff P.

Interview on 5/13/15 at 10:50 A.M. with direct care staff O revealed if he/she observed a staff member being verbally inappropriate to a resident he/she would report it to the nurse.

Interview on 5/13/15 at 2:31 P.M. with licensed nursing staff J revealed he/she felt it was very important for staffto treat the residents with dignity.

Interview on 5/13/15 at 2:41 P.M. with direct care staff P revealed on the day of the incident he/she gave verbal encouragement to the resident multiple times to use the restroom but he/she frequently hesitated and took his/her time to go to the bathroom resulting in incontinence. Staff P reported the resident had incontinence to the point of leaking urine from his/her brief twice that

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day. Staff P stated that he/she told the resident that he/she was on a toileting schedule and needed to follow that to retrain his/her bladder. He/she stated that he/she had used the words, "you have to," which is what he/she felt that he/she had done wrong. Staff P felt that his/her words could have been taken as offensive and made the resident feel undignified.

Interview on 5/13/15 at 3:33 P.M. with administrative nursing staff D revealed he/she expected for all staff to treat the resident's with respect and dignity.

The policy provided by the facility with a revision date of 3/30/07 regarding dignity rounds revealed rounds that focus on observation of dignity issues were the "best practice" to assure consistent practices that enhanced resident quality of life.

The facility failed ensure all staff member treated this cognitively impaired resident with a history of depression.

Findings included:

- Resident #12's quarterly MDS dated 03/01/2015 revealed the resident scored 9 (moderate impaired cognition) on the Brief Interview for Mental Status, did have delusions, hallucinations or behaviors, and was occasionally incontinent of urine.

The resident's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 12/02/2014 revealed the resident had a diagnosis of dementia and required extensive staff assistance with bed mobility, transfers and toileting. The CAA included the resident was incontinence of

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urine throughout the day and would void appropriately at times when toileted.

The resident's care dated 11/25/15 and revised 3/6/15 included staff approached the resident warmly and positively at all times and provided consistent caregivers to the extent possible.

Review of a concern/grievance report dated 12/16/14 documented the resident stated that on the night shift 12/15/14 into 12/16/14, he/she turned on his/her call light because he/she needed to use the bathroom. Licensed nurse L answered the resident's call light and told the resident he/she would be right back. The resident waited about 30 minutes and then re-activated his/her call light. Licensed nurse L came back and still did not take the resident to the bathroom. Licensed nurse L told the resident that he/she did not need 2 pillows and licensed nurse L "ripped" the pillow out from under the resident and the pillow scraped the resident's forehead. Licensed nurse L left the room and the resident turned his/her call light back on because he/she still needed to use the restroom. The resident stated another nurse came into the room and stated he/she would inform licensed nurse L. The resident stated he/she ended up waiting so long that he/she was forced to "pee" in his/her pants. When licensed L reentered the resident's room, licensed nurse L made the resident stay in bed while he/she changed the resident and licensed nurse L was rough when turning the resident and the resident's right hip was hurt. The resident informed licensed nurse L his/her right hip hurt from him/her pushing on it and licensed told the resident he/she would have a nurse get him/her a pain pill. The form included the social service designee observed a small red

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scrape on the upper left side of the resident's forehead.

Review of the facility's investigation dated 12/17/14 documented the resident stated licensed nurse L made him/her wait for 30 minutes and would not toilet him/her. Licensed nurse L ripped a pillow out from under the resident's head and the resident sustained a scrape on his/her left forehead. When licensed nurse L changed the resident because he/she was soiled the resident stated licensed nurse L was rough with him/her while turning her and hurt his/her hip when he/she pushed on it.

The investigation included administrative nursing staff E interviewed the resident and noted an abrasion on the left side of the resident's forehead approximately 4 centimeters in length. Administrative nursing staff E also noted three small finger tip size bruises on the resident's right hip.

On 5/12/15 at 3:45 P.M. the resident sat in a chair in his/her room and related the incident to the surveyor. The resident became tearful when he/she spoke of soiling his/her pant. The resident stated during the incident he/she did not say anything to licensed nurse L because he/she feared it would make the situation worse. The resident showed the surveyor a picture of him/her with the abrasion sustained during the incident on night shift of 12/15/14 into 12/16/14. Observation revealed a prominent area on the resident's left forehead that appeared as a gash/abrasion that measured approximately 3 centimeters.

On 5/13/15 at 9:20 A.M. administrative staff A stated the resident was upset by the incident and

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F 241	Continued From page 25 could still recall the incident. The facility's Dignity Rounds Policy and Procedure revised 3/30/2007 included the facility conducted rounds that focused on observation of dignity issues to assure consistence practices that enhanced quality of life. The facility failed to promote care that enhanced the dignity of this resident that had to wait a prolonged period of time to use the bathroom and became incontinent as a result and sustained bruises and an abrasion.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. The sample included 20 residents. Based on observation, record review, and interview the facility failed to assess and provide 1 resident (#47) with his/her preferences for bathing frequency of 3 residents reviewed for choices. Findings included: - The annual Minimum Data Set (MDS) dated 8/8/14 for resident # 47 revealed a Brief Interview	F 242		

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for Mental Status (BIMS) score of 15, indicating no cognitive impairment. The resident reported the following areas as very important to him/her: choosing his/her clothes to wear, taking care of his/her personal belongings, and choosing his/her bathing type.

The quarterly MDS dated 4/12/15 BIMS score of 7, indicating severe cognitive impairment. He/she required extensive assistance from 1 staff member for walking in the corridor, locomotion on the unit, toilet use, and bathing.

The 8/8/14 Care Area Assessment (CAA) regarding activities of daily living (ADLs) revealed the resident required extensive assistance from 1 staff member for bed mobility, dressing, and bathing.

Review of the temporary care plan dated 8/13/13 provided by the facility lacked documentation of the resident's preferred showering frequency.

The care plan with a revision date of 4/17/15 revealed the resident had a history of depression and staff were to provide him/her with an environment that was calm and non-stressful. He/she required assistance from staff for grooming and personal hygiene.

Review of the undated quarterly activity assessment provided by the facility failed to address the resident's preferred showering frequency.

The social services note dated 1/26/15 at 10:22 A.M. revealed the resident did not like to take showers due to getting cold but he/she knew he/she needed to take at least 1 shower per

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week.

Observation on 5/13/15 at 7:20 A.M. revealed the resident rested in bed with his/her eyes closed.

Interview on 5/11/15 at 10:53 A.M. with the resident revealed he/she was scheduled for 2 showers per week and he/she would prefer to only shower once per week. The resident reported the staff knew he/she preferred to shower once per week.

Interview on 5/12/15 at 5:05 P.M. with administrative nursing staff E revealed the staff documented resident preferences on the temporary care plan and then were reviewed quarterly with the activity assessment.

Interview on 5/13/15 at 10:50 A.M. with direct care staff O revealed he/she was unsure what staff member assessed for resident preferences but thought it was done upon admission. Staff O reported the pocket care plans carried by the direct are staff did not indicate the resident's preferred showering frequency.

Interview on 5/13/15 at 11:06 A.M. with licensed nursing staff I revealed staff asked the residents about showering preferences upon admission but not specifically about the frequency of showering. Staff I reported the facility was set up for residents to receive 2 showers per week. Staff I thought the care plan would indicate if the resident preferred a different frequency from the facility's protocol for 2 per week.

Interview on 5/13/15 at 2:41 P.M. with direct care staff P revealed he/she was unsure how the facility determined resident preferences. He/she

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F 242	Continued From page 28 thought the facility would allow a resident to shower once a week because they always had the right to refuse. Interview on 5/13/15 at 3:33 P.M. with administrative nursing staff D revealed the facility used to have a resident data set with more specific questions about preferences but no longer used that form. Staff D stated the facility had realized they needed to do something about that. Staff D stated the resident should be able to receive the number of baths that they desire. Staff D stated he/she and the assistant director of nursing create the bath schedule after asking the residents when they would like their baths or showers. The 8/1/04 policy provided by the facility regarding the resident preference interview failed to address resident preferences regarding bathing frequency. The undated policy provided by the facility regarding baths, tubs, showers revealed baths should follow a frequency schedule suitable to the residents' personal preferences as much as possible. The facility failed to assess and provide the desired number of showers per week for this resident.	F 242		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280		

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changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
- The significant change in status Minimum Data Status (MDS) dated 3/3/15 for resident #73 revealed a Brief Interview for Mental Status (BIMS) score of 7 (severe cognitive impairment). The resident required extensive assistance of two plus (2+) persons for toileting, and was always incontinent of bladder.

The Urinary Incontinence Care Area Assessment (CAA) dated 3/3/15 revealed the resident had a decline in continence and was frequently incontinent of bowel and bladder. The resident required extensive assistance and a two person transfer with toileting. The resident was not always aware if she/he required toileting.

The urinary incontinence care plan dated 3/6/15 revealed the resident was frequently incontinent of urine and had some control when toileted on

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schedule. Staff would initiate a scheduled toileting and bladder retraining plan based on an assessment as needed. Staff would observe for skin irritation and redness daily, provide incontinence pads, assess for symptoms of a urinary tract infection (UTI) (a bladder infection), provide verbal cueing, and continue ongoing assessment to the resident's voiding pattern. A urinal woud be kept at the resident's bedside within reach and she/he would be assisted to the bathroom or commode as needed.

The urinary incontinence care plan dated 3/6/15 lacked documentation of a toileting program.

The Bowel and Bladder Retraining Assessment dated11/26/14 revealed the rsident was frequently incontinent of urine, wore briefs, experienced functional incontinence (incontinence due to external factors), and was on a check and change program.

Observatin on 5/12/15 at 12:03 P.M. revealed the resident sat in the dining room after observing an activity and staff wheeled the resident to a dining table and had not toileted the resident.

Observation on 5/12/15 at 1:06 P.M. revealed staff toileted the resident in her/his bathroom and the back of the resident's pants and brief were wet with urine.

On 5/13/15 at 12:04 P.M. direct care staff O stated the resident was occassionally incontinent of urine and was toileted every two hours.

On 5/13/15 at 12:39 P.M. licensed nursing staff I stated the resident was alway incontinent of urine, staff checked and changed the resident every 2

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hours and would expect the care plan to reflect the resident's toileting program.

On 5/13/15 at 3:12 P.M. direct care staff U stated the resident was incontinent of urine and was toileted every two hours and not on a check and change program.

On 5/13/15 at 3:24 P.M. administrative nuring staff E stated the resident was always incontinent of urine, was on a toileting program, was checked and changed every 2 hours, and the care plan should have included the resident's toileting program.

The facility failed to review and revise a urinary care plan for this cognitively impaired dependent resident with urinary incontinence.

Findings included:

- Resident #26's Quarterly Minimum Data set (MDS) dated 3/15/15 identified the resident scored 8 (moderately impaired cognition) on the Brief Interview for Mental Status (BIMS) and required total assistance for bed mobility, transfer, locomotion on and off of the unit, toilet use, personal hygiene, and bathing. He/she was always incontinent of bladder and frequently incontinent of bowl. He/she was on a toileting program.

The residents Urinary Incontinent Care Area Assessment (CAA) dated 12/17/14 documented the resident was frequently incontinent of bowel and bladder. He/she had been disabled and required full time care giver. Staff would proceed with the plan of care to provide the assistance needed with incontinence and encourage toilet

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use on a schedule rather than soil his/her briefs.

The revised care plan dated 3/20/15 documented the resident was frequently incontinent of urine and bowel and chose at times to soil his/her brief as he/she felt it was easier than toileting. Staff should initiate a scheduled toileting plan based upon the assessment, check and change him/her every two hours as needed and observe skin daily for irritation or redness. Staff provided incontinence pads and ongoing assessment of his/her voiding pattern, color, clarity and character of urine. The resident would be assessed for symptoms of urinary tract infection (UTI) (an infection in any part of the urinary system, kidneys, bladder, or urethra). Staff was to encourage the use of the bedside commode or bedpan at night and assist to the bathroom as needed.

The resident lacked a 3 day voiding diary assessment.

The Bladder Retraining Quarterly Review dated 3/16/15 revealed the resident never voided without incontinence. He/she was incontinent of stool. He/she was completely immobile or needed assistance from more than one side to walk to the bathroom or transfer to the toilet/commode and managing clothing. He/she was forgetful but could follow commands. He/she was sometimes aware of his/her toileting needs but he/she did not have the ability to participate in a bowel and bladder retraining program, the resident lacked both the physical and cognitive ability needed to retrain musculature of bowel or bladder. The resident rarely knew when he/she had to use the restroom and he/she was incontinent of bowel and bladder daily.

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An observation on 5/13/15 at 9:25 A.M. the resident was transferred to his/her bed by staff for incontinence care. His/her incontinence pad was fully saturated with urine. His/her peri area was red, incontinence care was provided and he/she was left in his/her bed to rest.

An interview on 5/12/15 at 4:53 P.M. with resident #26 stated staff told him/her to wet his/her self because he/she wore incontinence briefs. .

An interview on 5/12/15 at 4:57 P.M. with direct care staff S stated the resident was incontinent of bowel and bladder. Staff tried to check him/her every 2 and a half hours for wetness. The resident did not tell staff if he/she was wet. Staff S changed the resident in his/her bed because he/she did not know if the resident could sit up by his/her self.

An interview on 5/12/15 AT 5:00 P.M. with direct care staff T stated the resident went to the bathroom in his/her brief. He/she leaned back and would slide when he/she sat on the toilet. Staff T changed the resident in his/her bed and told the resident to go in his/her brief. Staff T stated he/she did not check the resident as scheduled due to short staffing. He/she stated his/her shift started at 2:00 P.M. and was told in his/her report the resident was changed around lunch time. Staff T had not checked or changed the resident during his/her shifts at that time.

An interview on 5/12/15 at 1:33 P.M. with licensed nursing staff H stated the resident preferred to "pee" in his/her pants and when he/she does, staff changed him/her promptly.
An interview on 5/12/15 at 1:33 P.M. with licensed

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nursing staff K stated the resident was incontinent of bowel and bladder. Staff changed his/her brief and provided peri care every 2 hours. The resident was somewhat oriented and staff usually checked him/her because he/she did not always tell staff when he/she was wet. Staff K expected staff to check and change the resident every 2 to 3 hours since he/she was regularly incontinent. The aides took the resident to the bathroom for bowel movements but he/she would use his/her brief most of the time. The resident was not supposed to "go" in his/her brief. Staff K was not aware the resident was unable to sit on the toilet.

An interview on 5/13/15 at 10:42 A.M. with licensed nursing staff I stated the resident was always incontinent of bowel and bladder and staff did a check and change every 2 hours. The resident required a Hoyer lift for transfer and staff f had to lay the resident down to change his/her brief. The resident was not able to tell staff he/he needed to be toileted. The resident was always incontinent so staff did not use a voiding diary for him/her. The resident would not sit on a toilet for anyone and staff was not supposed to tell the resident to urinate in his/her brief. The resident sat on the bed pad for comfort rather than incontinence. The resident was a 2 person assist with a gait belt. The care plan should have removed taking the resident to the bathroom because he/she could not use the toilet.

An interview with administrative nursing staff F stated he/she expected staff to check and change the resident every 2 hours. If the resident could not be toileted and that needed to be removed from the care plan. It was presumptive of staff to add to the care plan that the resident chose to use his/her brief rather than be toileted. The only

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assessment completed was the bladder retraining quarterly review provided.

The undated resident care plan policy documented each resident had a plan of care that was current, individualized, and consistent with the MDS triggers. The plan of care should be updated more often as the residents condition or needs changed.

The facility failed to review and revise a urinary care plan for this cognitively impaired dependent resident with urinary incontinence.

The facility had a census of 55 residents. The sample size was 20. Based on observation, interview and record review the facilty failed to revise the care plan for 1 resident (#48) for fall interventions and two resident for toileting program. (#73, #26)

Findings included:

- Resident #48's physician order sheet dated May 2015 revealed a diagnoses of aftercare traumatic fracture of hip (broken bone).
The Quarterly Minimum Data Set (MDS) dated 03/22/2015 revealed a Brief Interview for Mental Status(BIMS) score of 9 which indicated moderate cognitive impairment. He/She had a Mood score of 9 which indicated mild depression. He/She required extensive assistance with transfers; limited assistance with locomotion on the unit, and he/she used a wheelchair. He/She was frequently incontinent of bowel and bladder.

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The annual MDS dated 09/14/2014 revealed a BIMS of 12 which indicated moderate cognitive impairment. He/she required extensive assistance with transfers and was only able to stabilize with staff assistance. He/she was frequently incontinent of bladder and bowel.
The fall Care Assesment Area (CAA) dated 09/14/2014 revealed his/her balance was impaired related to weakness and abdominal debility related to Chronic Obstrutive Pulmonary Disease (COPD (progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) . He/she had not experienced falls in the last 90-days and staff needed to place shoes on that were appropriate for transfer and ambulation. He/she required one assist for transfers and ambulation.
The revised care plan dated 03/27/2015 revealed he/she desired to watch TV and read while sitting up on the side of the bed, which placed him/her a high risk for falls. He/She stayed up at night drinking coffee and dozed off at his/her bedside. Staff were to remind him/her to ask for assistance for all transfers, monitor for change in condition that may warrant increased supervision/assistance and remind him/her to use the call light. The staff placed anti-skid strips to the floor on the side of the bed that he/she arose from, placed his/her chair next to the bed and encouraged him/her to sit in the chair rather than on the bed side. On 01/20/2015 a low bed was placed in his/her room.
The care plan lacked the removal of the reclincer and a pole placed at bedside and the use of non-skid shoes.
A nurse's note dated 01/14/2015 at 10:48 P.M. revealed the facility purchased slip resident shoes for him/her after he/she slipped from the edge of

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F 280	Continued From page 37 the bed. An observation on 05/12/2015 at 7:30 A.M. revealed the resident was not wearing slip resistant shoes to breakfast. An unidentified aide stated she was wearing slip resistant socks. An observation on 05/12/2015 at 11:14 A.M. revealed the resident did not have a recliner in his/her room. An observation on 05/13.2015 at 2:07 P.M. revealed the resident was not wearing slip resistant shoes. On 05/13/2015 at 11:14 A.M. direct care staff P stated the recliner was removed from the residents room because it was causing him/her to fall. The facility policy revealed between Interdisciplinary Conferences, all disciplines update Plan of Cares using the proper procedure for entering and discontinuing items. The facility failed to update the resident's care with a history of falls.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		

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prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
The facility had a census of 55 residents. The sample included 20 residents. Based upon observation, record review and interview the facility failed to develop and implement timely interventions to prevent the development and to promote healing of a pressure ulcer that worsened for 1 (#51) resident sampled for pressure ulcers.

Findings included:

- Resident #51's May 2015 Physician Order Sheet (POS) identified the resident admitted to the facility on 4/10/15 with diagnoses that included leg fracture (broken bone), anemia and Stage 3 kidney disease (a condition in which the kidneys lose the ability to remove waste and balance fluids). The POS included the resident had received a multivitamin daily since 4/10/15, Zinc sulfate (dietary supplement) 220 milligrams (mg) daily, Vitamin C (dietary supplement) 500 mg twice a day (BID) and Arginaid (a supplement used to aid in wound healing) daily for wound healing since 4/22/15.

The resident's admission Minimum Data Set (MDS) dated 4/17/15 identified the resident scored 13 (cognition intact), had no behaviors, required extensive staff assistance with bed mobility, dressing, transfers, toilet use and personal hygiene. The activity of walking in the room/corridor did not occur and the resident was totally dependent upon staff for locomotion on/off the unit. The MDS recorded the resident was

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always continent of urine, fell in the last 2 to 6 months prior to admission and sustained a fracture related to a fall in the 6 months prior to admission. The MDS identified the resident weighed 143 pounds and had not experienced a weight loss, was at risk for the development of pressure ulcers, had no unhealed pressure ulcers, utilized a pressure relieving device in his/her chair and on his/her bed and was on a turning/repositioning program.

The resident's 14 day Payment Prospective System (PPS) assessment dated 4/24/15 identified the resident had (1) Stage 3 pressure ulcer not present upon admission, the pressure ulcer measured 4.0 centimeters (cm) by 5.0 cm and identified slough (non-viable) as the most severe tissue type.

The resident's Activity of Daily Living (ADL) Care Area Assessment (CAA) dated 4/20/15 documented the resident had impaired mobility and required extensive staff assistance with mobility, and ADL tasks. The resident had right side weakness and a flaccid right arm and required extensive staff assistance with dressing, toileting and personal cares.

The resident's Nutritional CAA dated 4/20/15 included the resident received a mechanical soft diet.

The resident's Pressure Ulcer CAA dated 4/20/15 documented the resident required staff assistance with bed mobility and repositioning. Staff repositioned the resident at least every 4 hours and as needed. The resident had Panacea (pressure reducing) mattress on his/her bed to help with pressure reduction. The resident had

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impaired mobility due to a recent surgery to repair his/her fractured right hip and the resident had a surgical wound. The resident was continent of urine and used a bed pan most of the time. The resident had renal insufficiency, a diagnosis of peripheral vascular disease (PVD-- abnormal condition affecting the blood vessels) and had the potential for impaired skin integrity and pressure ulcers.

The resident's Braden Scale (scale used to predict the development of pressure ulcers) dated 4/13/15 identified the resident scored 16 and was at a mild risk for the development of pressure ulcers.

The resident's care plan dated 4/17/15 included the resident had pain related to a fracture with surgical repair, had a diagnosis of PVD, and was non-weight bearing on his/her right leg. Staff monitored the resident for pedal edema (swelling of the feet), monitored for numbness, coldness, tingling, skin breakdown, swelling or pain in his/her right leg and calf area. The resident was unable to transfer independently and utilized a mechanical lift for all transfers. The resident received a mechanical soft diet and the dietician evaluated the resident's nutritional status. The resident was at risk for the development of pressure ulcers related to impaired mobility and mild paralysis in his/her right arm. Staff repositioned the resident every 2 hours while awake and per resident request. Staff educated the resident on the risk factors for the development of pressure ulcers and required staff assistance with repositioning to avoid skin friction/shearing. Staff observed the resident's

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skin each day during routine care and notified the resident's physician/responsible party if the resident developed a pressure ulcer. All of the above interventions had an onset date of 4/17/15. Undated entries to the resident's care plan included the resident had a pressure ulcer on his/her right lower leg due to an immobilizer and the physician's order included do not remove. The immobilizer was discontinued. The resident had a low air loss mattress and received Vitamin C 500 mg BID and Zinc 220 mg for 3 weeks. A hand written entry dated 4/15/15 included the resident received Keflex (antibiotic) 500 mg four times a day (QID) for 10 days. A hand written entry dated 4/24/15 included the resident utilized a pressure relief foam boot on his/her right foot when in bed or supine (lying on the back and the face up) to promote healing of the pressure ulcer. An entry dated 4/29/15 included the resident received Cefepime (an antibiotic) and Vancomycin (an antibiotic) every 24 hours for cellulitis (skin infection caused by bacteria characterized by heat, redness and swelling) of the wound.

The resident's undated temporary care plan included the resident required assistance of 2 staff for transfers and required staff assistance with ADLs. The care plan included an entry dated 4/11/15 that the resident received physical therapy 5 times a week for 30 days. The temporary care plan did not include the resident was at risk for the development of pressure ulcer or interventions to minimize pressure.

The resident's hospital transfer orders dated 4/10/15 included the resident had a right femur fracture, do not remove the immobilizer and to follow up with the orthopedic surgeon on 4/15/15.

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A nurse's note (NN) dated 4/16/15 timed 12:41 P.M. documented the resident had a small open blister area to the underside of his/her right lower extremity, staff cleansed the area and placed a dressing over the area. The note did not include any measurements of the wound or any description of the blister.

Review of the nurse's notes for 4/17/15, 4/18/15, and 4/19/15 documented the resident had an ulcerated area on the back of his/her right lower extremity. The notes did not include measurements or description of the ulcerated area.

A skin assessment dated 4/18/15 documented the dressing to the open blister was intact. There were no measurements or description included on the skin assessment regarding the blister.

A skin assessment dated 4/25/15 documented the resident's right lower leg had an open area. No measurements or description of the area was included.

A skin assessment dated 5/2/15 included staff performed a treatment on the resident's right lower calf. No measurements or description of the pressure ulcer was included.

A skin assessment dated 5/9/15 documented the resident had a Stage 4 pressure ulcer on his/her right lower calf.

A wound consultant report dated 4/20/15 included the resident had a cast and immobilizer and after removal the resident had a wound on the back of his/her right lower leg. The note included the

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wound was a Stage 3 pressure ulcer that measured 4.40 centimeters by 5.0 cm with a depth of 0.10 cm and 20% of the wound bed was yellow in color.

A wound consultant report dated 4/27/15 included the Stage 3 pressure ulcer measured 4.5 cm by 5.8 cm with a depth of 0.10 cm. Twenty percent of the wound bed was yellow and 80% was black.

A wound consultant report dated 5/4/15 included the Stage 3 pressure ulcer on the back of the resident's right lower leg measured 5.10 cm by 5.40 cm with a depth of 0.10 cm and 80% of the wound bed was yellow and 10% was black.

A wound consultant report dated 5/11/15 documented the Stage 3 measured 4.60 cm by 5.80 with a depth of 0.10 and the wound bed was 80% yellow.

An undated orthopedic surgeon progress note documented no more knee immobilizer; cover the wound with a dressing and to start the resident on Keflex 500 mg QID (four times a day) for 10 days and for the resident to follow up with the orthopedic surgeon on Monday.

The orthopedic surgeon's progress note dated 4/22/15 documented the resident started on an antibiotic until the calf wound healed, range of motion to the resident knee, non-weight bearing and to follow up in 2 weeks.

An undated orthopedic surgeon progress note documented the wound on the resident's right leg was worse, the resident needed to go to a wound center, needed to see an infectious disease physician and a plastic surgeon. The facility was

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to perform wet to dry treatment twice a day.

The resident's primary care physician progress note dated 4/23/15 included the wound on the resident right leg was likely a pressure ulcer from the recent cast.

The resident's primary care physician's progress note dated 4/29/15 included the resident's upper right lower extremity wound had increased redness, heat and pain and the orthopedic surgeon started the resident on Keflex for possible surgical wound treatment. The pressure wound on the resident's lower right calf was a Stage 2.

The resident's primary physician's progress note dated 5/7/15 documented the resident saw the orthopedic surgeon today and he/she was upset that the resident's lower extremity wound was worse than when he/she saw it 2 weeks ago.

A physician's order dated 4/15/15 included to start the resident on Keflex 500 mg QID for 10 days per orthopedic surgeon.

A physician's order dated 4/20/15 included for the wound care company to evaluate and treat the resident.

A physician's order dated 4/30/15 included for the resident to wear the pressure relief foam boot on his/her right foot when in bed or supine to aid in the healing of the ankle pressure ulcer.

An Occupational Therapy (OT) note with a start of care (SOC) date of 4/13/15 and signed 4/27/15 documented the OT fabricated a pressure relief

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boot in order to allow a better option for off-loading pressure to the posterior/lateral (back/side away from the middle) aspect pressure ulcer on the resident's right ankle.

An OT note with a date of service of 4/22/15 included the resident saw the orthopedic surgeon on 4/22/15 and nursing staff reported the resident had a Stage 3 pressure ulcer on the back of his/her right calf from the cast. OT provided the resident with a better fitting wheelchair and the resident reported increased comfort.

A laboratory report dated 4/6/15 recorded the resident's total protein was at 5.9 grams/deciliter (g/dl) (normal reference range 6.5 to 8.2 g/dl and the resident's albumin was at 3.1 g/dl (normal reference range 3.5 to 4.8 g/dl).

The resident's weight logs recorded the following weights:
04/10/15: 143 pounds
04/15/15: 137 pounds (6 pounds or 4.19 percent of his/her body weight)
04/22/15: 134 pounds (9 pounds or 6.29 percent of his/her body weight since 4/10/15)

During this time frame the resident developed a pressure ulcer on the posterior aspect of his/her right leg and the pressure ulcer worsened.

A Nutritional History/Assessment dated 4/29/15 documented the resident weighed 134; the resident had a pressure ulcer on the posterior aspect of his/her right lower leg. The resident received Lasix (a diuretic), a multivitamin, Vitamin C, Zinc, and Arginaid. The registered dietician (RD) did not make any recommendations.

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A RD progress note dated 5/8/15 documented the resident weighed 134 pounds, the resident's admission weight was 143 pounds and the resident had a 9 (6.2%) pound weight loss. The resident had edema on admission and it was resolving. The resident had a pressure ulcer on his/her right lower leg. The RD spoke with the resident about supplements, the resident stated he/she had not tried 2 Cal, health shakes or fortified foods (nutritional supplements to increase calories and protein). The resident liked ice cream and the RD spoke with the charge nurse about implementing them. The RD recommended the resident receive a magic cup (high calorie dessert) at lunch each day and for staff to add fortified food to the resident's current diet.

Review of the resident's clinical record lacked evidence the facility monitored the resident's right lower extremity from admission on 4/10/15 until 4/15/15. The clinical record also lacked evidence the facility measured, staged or thoroughly assessed the pressure ulcer from 4/15/15 until 4/20/15. The clinical record also lacked evidence the facility started nutritional interventions until 4/22/15 (7 days after staff were aware of the pressure ulcer).

On 5/12/15 at 11:00 A.M. and 2:30 P.M., the resident sat in the recliner in his/her room. Observation revealed a dressing in place on the resident's right lower extremity, the resident had on slipper socks and no foam boot or other device was in place. Further observation revealed the posterior aspect of the resident right leg rested directly on the raised foot rest of the recliner.

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F 314	Continued From page 47 On 5/13/15 at 6:50 A.M. the resident laid in bed on his/her back. Observation revealed a foam boot and a blue positioning device with curved up edges on the floor in the resident's room. On 5/13/15 at approximately 8:45 A.M. licensed nurse H performed the treatment on he distal aspect of the resident's right lower leg. Observation revealed the resident had a Stage 3 pressure ulcer that measured approximately 4.5 cm by 6.0 cm and the wound bed contained approximately 80% yellow slough. On 5/13/15 at 10:30 A.M. the resident sat in the recliner in his/her room with a pillow under his/her legs. Observation revealed the pillow was not properly positioned and the distal aspect of the resident's right leg rested on the foot rest of the recliner. On 5/13/15 at 11:15 A.M. direct care staff R stated the resident had a pressure ulcer on the posterior aspect of his/her lower calf. He/she stated staff placed a pillow under the resident's legs when he/she sat in the recliner to keep the resident's leg off of the foot rest of the recliner. Direct care staff R stated resident wore the foam boot when he/she was in bed. He/she stated night shift staff reported during the middle of the night the resident asked staff to remove the boot. He/she confirmed the boot was not in place this A.M. when the resident was in bed. On 5/13/15 at 11:42 A.M. physician staff KK stated immobilizer shift during standing and transfers which caused friction on the extremity. Therefore, even though the admitting physician's order included do not remove the immobilizer it	F 314		

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was the expectation staff removed the immobilizer each day to check and document on the status of the resident's skin. He/she stated after the pressure ulcer was first observed the expectation would be that staff staged, measured and assessed the pressure ulcer. Physician staff KK stated the pressure ulcer worsened.

On 5/13/15 at 12:31 P.M. licensed nurse H stated the immobilizer the resident wore prior to the development of the pressure ulcer was removable but the facility had strict physician's orders not to remove the device. On 4/15/15 the orthopedic surgeon observed the pressure ulcer on the back of the resident right lower leg after he/she removed the immobilizer. Licensed nurse H stated he/she was not on duty that day, and that he/she documented on the pressure ulcer on 4/16/15. Licensed nurse H stated at that time the pressure ulcer looked like a sheared area and was probably a Stage 2. He/she stated after the development of the pressure ulcer, OT fabricated a boot for the resident to wear. The boot had a cut out in the bottom and staff placed a pillow under the resident's leg when he/she sat in the recliner to keep the area from resting on the foot rest of the recliner. Licensed nurse H stated the pressure ulcer worsened. He/she stated during that time the resident was not eating much which contributed to the healing of the wound. Licensed nurse H stated the facility implemented nutritional interventions after the development of the Stage 2 pressure ulcer.

On 5/13/15 at 1:45 P.M. therapy consultant II stated he/she fabricated the foam boot after the development of the pressure ulcer. He/she stated the resident was to wear the foam boot when in bed and when in the supine position.

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Therapy consultant II stated staff was to place the blue curve up device under the resident's legs when he/she sat in the recliner.

During interview on 5/13/15 at approximately 4:00 P.M. with administrative nursing staff D and E; administrative nursing staff D stated the admitting physician's order included the staff was not to remove the immobilizer; therefore staff did not remove the immobilizer on a daily basis to check the resident's skin. He/she stated some physician's order for immobilizer include to remove once a day or once a shift to check the resident's skin but since the admitting physician's order included not to remove staff did not ask for clarification of the order. Administrative nursing staff D stated the wound consultant assessed the pressure ulcer on 4/20/15 and documented the pressure ulcer was a Stage 3. Administrative nursing staff D stated licensed nursing staff had assessed and documented on the pressure ulcer in the nurse's notes and on the skin assessment sheets since 4/16/15.

The facility Pressure Ulcer Monitoring Policy and Procedure dated 4/04 included upon detection of a pressure ulcer and each week following licensed staff documented the location, size and depth, description, drainage, necrosis (dead tissue) of the ulcer. The policy and procedure did not include nutritional interventions.

The facility failed to measure and adequately document on the pressure ulcer from 4/15/15 until 4/20/15. The facility failed to develop and implement timely interventions to prevent the development and promote healing of a pressure ulcer that worsened. The facility also failed to timely implement nutritional interventions after the

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents with a sample size of 20 residents. Based on observation, record review, and interviews, the facility failed to assess and /or provide toileting to meet the needs of 2 of 2 residents reviewed for incontinence. (#26,73) Findings included: - Resident #26's Quarterly Minimum Data set (MDS) dated 3/15/15 identified the resident scored 8 (moderately impaired cognition) on the Brief Interview for Mental Status (BIMS) and required total assistance for bed mobility, transfer, locomotion on and off of the unit, toilet use, personal hygiene, and bathing. He/she was always incontinent of bladder and frequently incontinent of bowl. He/she was on a toileting program.	F 315		

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The residents Urinary Incontinent Care Area Assessment (CAA) dated 12/17/14 documented the resident was frequently incontinent of bowel and bladder. He/she had been disabled and required full time care givers as well as his/her partner at home to provide extensive assistance at home. Staff would proceed with the plan of care to provide the assistance needed with incontinence and encourage toilet use on a schedule rather than soil his/her briefs.

The Activities of daily living (ADL's) CAA dated 12/17/14 documented the resident had poor balance, was dependent on others, and required 2 person extensive assist with transfers.

The revised care plan dated 3/20/15 documented the resident was frequently incontinent of urine and bowel and chose at times to soil his/her brief as he/she felt it was easier than toileting. Staff should initiate a scheduled toileting plan based upon the assessment, check and change him/her every two hours as needed and observed skin daily for irritation or redness. Staff provided incontinence pads and ongoing assessment of his/her voiding pattern, color, clarity and character of urine. The resident would be assessed for symptoms of urinary tract infection (UTI) (an infection in any part of the urinary system, kidneys, bladder, or urethra). Staff was to encourage the use of the bedside commode or bedpan at night and assist to the bathroom as needed.

The resident lacked a 3 day voiding diary assessment.

The Bladder Retraining Quarterly Review dated 3/16/15 revealed the resident never voided

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without incontinence. He/she was incontinent of stool. He/she was completely immobile or needed assistance from more than one side to walk to the bathroom or transfer to the toilet/commode and managing clothing. He/she was forgetful but could follow commands. He/she was sometimes aware of his/her toileting needs but e/she did not have the ability to participate in a bowel and bladder retraining program, the resident lacked both the physical and cognitive ability needed to retrain musculature of bowel or bladder. The resident rarely knew when he/she had to use the restroom and he/she was incontinent of bowel and bladder daily.

An observation on 5/12/15 at 1:51 P.M. the resident sat at the nurses ' station in his/her chair. At 2:34 P.M. the resident visited with a family member in the dining room. At 3:46 P.M. the resident continued to sit in his/her wheelchair and was moved to the nurses ' station. At 4:15 P.M. the resident was taken to the dining room by staff. At 5:13 P.M. the resident continued to sit in the dining room. He/she was not toileted for a duration of 4 ½ hours.

An observation on 5/13/15 at 9:25 A.M. the resident was transferred to his/her bed by staff for incontinence care. His/her incontinence pad was fully saturated with urine. His/her peri area was red, incontinence care was provided and he/she was left in his/her bed to rest.

An interview on 5/12/15 at 4:53 P.M. with resident #26 stated staff told him/her to wet his/her self because he/she wore incontinence briefs. .

An interview on 5/12/15 at 4:57 P.M. with direct care staff S stated the resident was incontinent of

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bowel and bladder. Staff tried to check him/her every 2 and a half hours for wetness. The resident did not tell staff if he/she was wet. Staff S changed the resident in his/her bed because he/she did not know if the resident could sit up by his/her self.

An interview on 5/12/15 AT 5:00 P.M. with direct care staff T stated the resident went to the bathroom in his/her brief. He/she leaned back and would slide when he/she sat on the toilet when staff T tried to toilet the resident. Staff T changed the resident in his/her bed and told the resident to go in his/her brief. Staff T stated he/she did not check the resident as scheduled due to short staffing. He/she stated his/her shift started at 2:00 P.M. and was told in his/her report the resident was changed around lunch time. Staff T had not checked or changed the resident during his/her shifts at that time.

An interview on 5/12/15 at 1:33 P.M. with licensed nursing staff H stated the resident preferred to "pee" in his/her pants and when he/she does, staff changed him/her promptly.

An interview on 5/12/15 at 1:33 P.M. with licensed nursing staff K stated the resident was incontinent of bowel and bladder. Staff changed his/her brief and provided peri care every 2 hours. The resident was somewhat oriented and staff usually checked him/her because he/she did not always tell staff when he/she was wet. Staff K expected staff to check and change the resident every 2 to 3 hours since he/she was regularly incontinent. The aides took the resident to the bathroom for bowel movements but he/she would use his/her brief most of the time. The resident was not supposed to "go" in his/her brief. Staff K was not

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aware the resident was unable to sit on the toilet.

An interview on 5/13/15 at 10:42 A.M. with licensed nursing staff I stated the resident was always incontinent of bowel and bladder and staff did a check and change every 2 hours. The resident required a Hoyer lift for transfer and staff f had to lay the resident down to change his/her brief. The resident was not able to tell staff he/he needed to be toileted. The resident was always incontinent so staff did not use a voiding diary for him/her. The resident would not sit on a toilet for anyone and staff was not supposed to tell the resident to urinate in his/her brief. The resident sat on the bed pad for comfort rather than incontinence. The resident was a 2 person assist with a gait belt. The care plan should have removed taking the resident to the bathroom because he/she could not use the toilet.

An interview with administrative nursing staff F stated he/she expected staff to check and change the resident every 2 hours. If the resident could not be toileted and that needed to be removed from the care plan. It was presumptive of staff to add to the care plan that the resident chose to use his/her brief rather than be toileted. The only assessment completed was the bladder retraining quarterly review provided.

An interview on 5/13/15 at 4:14 P.M. with administrative nursing staff E stated the resident did not qualify for a toileting program because of his/her score on the bowel and bladder retraining quarterly review. No other assessment was completed for this resident.

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The revised 11/05 Bowel and Bladder assessment policy documented documentation of toilet plans and outcomes would be placed in the medical record updating and revising the plan of care as indicated.

The facility failed to assess the residents toileting needs to develop a toileting program for resident #26 who was incontinent of urine.

- The significant change in status Minimum Data Status (MDS) dated 3/3/15 for resident #73 revealed a Brief Interview for Mental Status (BIMS) score of 7 (severe cognitive impairment). The resident required extensive assistance of two plus (2+) persons for toileting, and was always incontinent of bladder.

The Urinary Incontinence Care Area Assessment (CAA) dated 3/3/15 revealed the resident had a decline in continence and was frequently incontinent of bowel and bladder. The resident required extensive assistance and a two person transfer with toileting. The resident was not always aware if she/he required toileting.

The urinary incontinence care plan dated 3/6/15 revealed the resident was frequently incontinent of urine and had some control when toileted on schedule. Staff would initiate a scheduled toileting and bladder retraining plan based on an assessment as needed. Staff would observe for skin irritation and redness daily, provide incontinence pads, assess for symptoms of a urinary tract infection (UTI) (a bladder infection), provide verbal cueing, and continue ongoing

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assessment to the resident's voiding pattern. A urinal would be kept at the resident's bedside within reach and she/he would be assisted to the bathroom or commode as needed.

Record review on 5/12/15 at 3:50 P.M. lacked evidence of a 3-day voiding diary.

The Admission Resident Data Assessment dated 11/26/14 revealed the resident required extensive assistance of two plus persons for toileting, was occasionally incontinent of urine, and unable to determine a urinary toileting program.

The Bowel and Bladder Retraining Assessment dated11/26/14 revealed the resident was frequently incontinent of urine, wore briefs, experienced functional incontinence (incontinence due to external factors), and was on a check and change program.

Observation on 5/12/15 at 12:03 P.M. revealed the resident sat in the dining room after observing an activity and staff wheeled the resident to a dining table and had not toileted the resident.

Observation on 5/12/15 at 1:06 P.M. revealed staff toileted the resident in her/his bathroom and the back of the resident's pants and brief were wet with urine.

On 5/13/15 at 12:04 P.M., direct care staff O stated the resident was occasionally incontinent of urine and was toileted every two hours. Certified Nursing Assistants (CNA) would initiate a voiding diary when informed by the charge nurse.

On 5/13/15 at 12:39 P.M. licensed nursing staff I

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F 315	Continued From page 57 stated the resident was always incontinent of urine, staff checked and changed the resident every 2 hours, and the Director of Nursing (DON) implemented the 3-day voiding diary. On 5/13/15 at 3:12 P.M., direct care staff U stated the resident was incontinent of urine and was toileted every two hours and not on a check and change program. On 5/13/15 at 3:24 P.M. administrative nursing staff E stated the resident was always incontinent of urine, was on a toileting program, was checked and changed every 2 hours, and the care plan should have included the resident's toileting program. On 5/12/15 at 4:57 P.M. administrative nursing staff E stated the resident was incontinent of urine and scored a six on the Bowel and Bladder Retraining Assessment which indicated the resident was not eligible for bladder training and staff would not initiate a 3-day voiding diary. The revised policy and procedure dated November 2005 titled Bowel and Bladder Assessment indicated staff used the assessment to evaluate residents admitted to the facility to ensure provision of appropriate treatment and services to assist residents in maintaining their continence. Nursing staff would initiate an assessment upon admission, quarterly, annually, and with a significant change. The facility failed to provide a complete urinary assessment for this cognitively impaired dependent resident with urinary incontinence.	F 315		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 55 residents. The sample included 20 residents. Based on observation, record review, and interview, the facility failed to follow a fall care plan for 1 (#73) of three resident observed for falls and failed to safely store chemicals for 1 of 4 hallways.

Findings included:

- The significant change in status Minimum Data Set (MDS) dated 3/3/15 revealed a Brief Interview for Mental Status (BIMS) score of 7 (severe cognition). The resident required extensive assistance of two plus (2+) persons with bed mobility, transfers, toileting, and extensive assistance of one person with walking in the corridor. The resident was not steady and stabilized with staff assistance with moving from seated to standing position, walking, moving on/off the toilet, and surface-to-surface transfer. The resident lacked impairments to her/his upper/lower extremities and used a wheelchair for mobility. The resident was always incontinent of urine, and had one noninjury fall since admission, reentry, or prior assessment.

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The Fall Care Area Assessment (CAA) dated 3/4/15 revealed the resident had a history of falling and slid from a recliner chair in her/his bedroom on 1/12/15.

The care plan updated on 4/15/15 for potential for poor safety awareness revealed staff would remind the resident to ask for staff assistance with all transfers, and would keep a call light within reach while in her/his room. Staff would place a non-skid one way slide to the resident's wheelchair and recliner, replace a rocker recliner with a solid based recliner, keep the resident's bed in lowest position when in bed, and two person assist with bathes.

The Fall Risk Review dated 12/3/14 revealed the resident was at risk for falls.

The Nursing Notes dated 1/12/15 at 7:47 P.M. revealed at 3:00 P.M. the resident's personal body alarm sounded and the resident was found laying on the floor in front of her/his recliner chair. The resident had a 5 centimeter (cm) hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to the lower occipital area (back of head).

On 5/12/15 at 1:06 P.M. staff transferred the resident from her/his wheelchair to a toilet and the resident's wheelchair seat did not have a one-way slide pad.

On 5/12/15 at 3:45 P.M., the resident sat in a reclined recliner chair and slid toward the footrest of the recliner chair. Staff transferred the resident from the recliner chair to wheelchair, the recliner chair did not have a one-way slide pad, staff did not place a one way slide pad in the resident's

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F 323	Continued From page 60 wheelchair. On 5/13/15 at 12:04 P.M., direct care staff O stated the certified nursing aide (CNA) resident care sheet indicated the resident used a one-way slide pad to prevent the resident from sliding out of the recliner chair and wheelchair. On 5/13/15 at 12:39 P.M., licensed nursing staff I stated the resident used a nonskid slide pad to prevent the resident from sliding out of her/his recliner and wheelchair. On 5/13/15 at 3:012 P.M. direct care staff U stated an incontinence pad was placed on the resident's recliner chair and was not aware the resident used a one-way slide pad. On 5/13/15 at 3:29 P.M. administrative nursing staff E stated the resident should have had a one way slide pad in her/his wheelchair and recliner to prevent the resident from sliding out of her/his wheelchair. The facility failed to follow a care planned fall intervention for this cognitively impaired dependent resident with a history of falls.	F 323		

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Findings included:

- An observation on 5/11/15 at approximately 8:15 A.M. the 300 hall linen closet revealed the following:
Super Sani-Cloth germicidal disposable wipes with "Keep out of reach of children" label. A container of Dispatch hospital cleaner disinfectant towels with bleach with "caution: keep out of reach of children, not to be used as baby wipes, keep container tightly sealed when not in use. Hazards to humans and domestic animals. Causes moderate eye irritation " on the label, and Disinfectant wipes, kills cold and flu virus with "keep out of reach of children, caution: causes moderate eye irritation " on the label.

An interview on 5/11/15 at 8:32 A.M. with administrative nursing staff F stated he/she was unaware the chemicals needed to be locked up and he//she removed the bottles.

An interview on 5/11/15 at 8:45 A.M. with administrative nursing staff D stated the wipes should have been in a locked closet.

An interview on 5/13/15 at 4:59 P.M. with administrative nursing staff E stated the facility housed 7 cognitively impaired and independently mobile residents in the facility.

The facility failed to store hazardous chemicals out of reach of residents.

F 325	483.25(i) MAINTAIN NUTRITION STATUS	F 325		

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F 325 SS=D	Continued From page 62 UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. The sample included 20 residents. Based on observation, record review, and interview the facility failed to consistently monitor food and supplement intake in order to monitor and prevent weight loss for 1 (#60) of 4 residents reviewed for nutritional status. Findings included: - The admission Minimum Data Set (MDS) dated 11/24/14 in the closed record of resident #60 revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating no cognitive impairment. He/she required extensive assistance from 2 or more staff members for walking in his/her room and the corridor, toilet use, and staff supervision and set up for eating. The resident had no swallowing or dental concerns. The 12/1/14 Care Area Assessment (CAA)	F 325		

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regarding nutrition revealed the resident had noted low protein levels prior to admission, and was under his/her ideal body weight.

The 11/28/14 care plan revealed the resident was under his/her ideal body weight. The dietitian evaluated the resident's nutritional status. Staff maintained a current list of his/her likes and dislikes for food choices, provided verbal cueing and encouragement, weighed him/her monthly, provided fortified foods at each meal, and provided snacks between meals.

Review of the clinical record revealed the following weights and dates:
11/18/14 equaled (=) 118 pounds (#)
11/24/14 = 114#
12/3/14 = 110#
12/10/14 = 108#
These readings revealed a total loss of 8.47 percent (%) of his/her body weight, or 10# in 22 days.

The 11/21/14 nutritional history and assessment revealed the resident had a low weight for his/her height. The dietitian recommended staff to provide 8 ounces of milk with each meal, 30 millimeters (ml) of Prostat (a dietary supplement) twice per day (BID), add fortified foods, and provide snacks three times per day (TID).

The November 2014 Meal Intake Record indicated for staff to document the % of the food consumed by the resident at each meal. The form lacked documentation of 11 out 37 meals.

The November 2014 medication and treatment administration record (MAR/TAR) indicated for staff to document when the resident consumed

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the recommended Prostat, the % intake of the fortified foods with each meal, and the % intake of the snacks provided between meals. The form revealed inconsistent documentation for the % intake for fortified foods with meals and % intake of snacks between meals.

The December 2014 Meal Intake Record indicated for staff to document the % of the food consumed by the resident at each meal. The form lacked documentation of 10 out 51 meals.

The December 2014 medication and treatment administration record (MAR/TAR) indicated for staff to document when the resident consumed the recommended Prostat, the % intake of the fortified foods with each meal, the % intake of the snacks provided between meals, and consumption of 2 cal 4 times a day (a dietary supplement). The form revealed inconsistent documentation for the % intake for fortified foods with meals and % intake of snacks between meals.

Interview on 5/13/15 at 11:18 A.M. with licensed nursing staff H revealed staff documented meal % intake for all residents and it should be done consistently especially for those with weight loss. Staff H also reported staff documented % intake of dietary supplements and it should be done consistently. He/she also said if a resident was frequently refusing supplements or meals then staff should document a progress note regarding that.

Interview on 5/13/15 at 1:36 P.M. with direct care staff R revealed the aides were responsible for documenting the % intake for each meal. Staff R reported the documentation should be consistent.

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F 325	Continued From page 65 Interview on 5/13/15 at 3:33 P.M. with administrative nursing staff D revealed staff was supposed to document meal % intake for all residents. Staff d stated he/she would like it consistently for all residents. The 4/04 policy provided by the facility regarding nutritional protocols for weight loss revealed the dietitian assessed residents identified with weight loss. During the review he/she reviewed meal intake. The facility failed to consistently monitor food and supplement intake in order to monitor and prevent weight loss for this resident.	F 325		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility had a census of 55 residents. Based on observation, record review, and interview the	F 354		

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F 354	Continued From page 66 facility failed to provide RN (Registered Nurse) coverage for 8 consecutive hours for 7 days a week. Findings included: - Record review of staffing schedules provided by the facility revealed the facility lacked RN shift coverage every weekend for approximately one year excluding the dates of January 25, 2015; March 8 and 15 2015; and April 4, 2015. An interview on 5/13/15 at 11:09 A.M. with administrative nursing staff D stated there was not RN staff on weekends, but the RN on call was available by telephone. The RN's that came did not stay for 8 consecutive hours on the weekends if they were called in. It had been approximately a year since the facility had RN coverage on the weekends. The facility failed to provide a policy on RN coverage. The facility failed to provide RN coverage for 8 consecutive hours in a 7 day week.	F 354		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 55 residents with one main kitchen serving all residents of the facility. Based on observation, interview, and record review, the facility failed to serve, store, and prepare food in a sanitary manner.

Findings included:

- Observation of the main kitchen during the initial tour of the facility on 5/11/15 at 7:15 A.M. revealed the ice machine filter was full of dust. Dishes were not inverted on a rack, or in front of a window. 2 plastic wrap holders, spice containers and a knife rack at the prep station and the robo coup were laden with grease. The bin containing thickener was soiled on the top, the flour bin had flour residue on the top, and was grease laden on the sides.

Lemonade in a container was not dated, dietary staff DD stated that was made this morning. 2 loaves of bread were open and not dated.

4 loaves of bread rested in a drawer with use by dates of April 8th, 11th, 27th, and May 6. The bread was hard and dietary staff DD stated it was for a particular resident, and he/she was out of facility for a while now.

The walk in refrigerator located in front of the freezer contained strawberries and hard boiled eggs that were not dated when the packages were opened.

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	175338	A. BUILDING _____ B. WING _____	05/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALDWIN HEALTHCARE & REHAB CTR	1223 ORCHARD LANE BALDWIN CITY, KS 66006

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F 371	Continued From page 68	F 371		

Review of the cook ' s refrigerator revealed macaroni and cheese dated 5/6/15, fish dated 5/8/15, key largo veggies dated 5/8/15, green beans dated 5/815, tomatoes dated 5/7/15, soup dated 5/7/15, corn dated 5/7/15 and BBQ dated 5/7/15. Dietary staff DD stated foods should be discarded if not used within 3 days.

Review of the facility policy for Food Storage dated 8/1/04 did not identify how long to keep foods that were previously cooked.

Interview on 5/11/15 at approximately 7:45 A.M. with dietary staff DD stated it is beach day today and lunch is a sloppy joe. He/she was serving the sloppy joes in a sand pail bucket, and stated it will be hard to maintain temperatures.

Review of the sanitization buckets revealed the strip registered at 100 parts per million (PPM), dietary staff DD stated the range was 50-100 PPM on the strips. The facility provided a policy for cart cleaning dated 8/1/04, the policy did not identify the range of PPM to use. Dietary staff DD stated there was no policy for the sanitization range.

Review of the product label for Sanibelt Mulit Range Sanitizer 4 listed to sanitize food processing equipment utensils and other food contact equipment under number #4 sanitize by immersing or use solution of the product 2 gallons of water at150-400 PPM for at least 60 seconds.

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F 371	Continued From page 69 During dining observation on 5/11/15 at 12:00 P.M. Unidentified staff serving food wiped his/her nose with gloved hands and continued to serve food from the table without changing gloves or washing hands. Dietary staff DD removed hamburger buns from the packages, placed the buns on paper plates using the same gloved hands, spooned sloppy joe on half of the bun and replaced the top of the bun using the same gloved hands. No tongs were used. Interview on 5/12/15 at 3:00 P.M. dietary staff DD confirmed he/she did not use tongs to dispense the hamburger buns on 5/11/15. Tongs should be used for this process. The facility failed to store prepare and serve food in a sanitary manner and failed to maintain appropriate sanitization ranges for cleaning surfaces.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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F 441	Continued From page 70 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility identified a census of 55 residents. Based on observation, record review, and interview the facility failed to disinfect frequently touched surfaces and failed to follow manufacturer's instructions for cleaning solutions while cleaning a resident's room. Findings included: - Observation of a room cleaning on 5/12/15 at 7:14 A.M. revealed housekeeping staff Z cleaned a resident room on the 100 hallway. Staff Z gloved his/her hands, entered the resident's	F 441		

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F 441	Continued From page 71	F 441		

room, emptied the trash cans into the cart's trash. Staff Z then changed gloves and sprayed Betco AF315 (disinfectant solution with a label stating a wet time of 10 minutes) onto the sink and the toilet. Approximately 3 minutes later staff Z used a clean rag and wiped down these surfaces. He/she then changed gloves and sprayed a rag with the same solution until it was damp. Staff Z then wiped down the resident's televisions, dressers, bedside tables, and window sills. He/she then swept and mopped the floors. Staff Z failed to wipe down light switches, call lights, and door knobs.

Interview on 5/12/15 at 7:35 A.M. with housekeeping staff Z revealed housekeeping staff were expected to follow the manufacturer's instructions for the use of the cleaning products. Staff Z acknowledged he/she did not disinfect the call lights, door knobs, or light switches and reported he/she should have done that.

Interview on 5/13/15 at 10:05 A.M. with housekeeping supervisor Y revealed he/she expected the housekeeping staff to follow the manufacturer's instructions regarding wet times. He/she also expected the staff to disinfect frequently touched surfaces during a room cleaning.

Interview on 5/13/15 at 1:02 P.M. with administrative nursing staff E revealed he/she expected housekeeping staff to follow manufacturer's instructions for cleaning products and disinfect frequently touched surfaces during room cleanings.

The 1/1/2000 policies provided by the facility regarding 5-step daily patient room cleaning,

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F 441	Continued From page 72 7-step daily washroom cleaning, complete room cleaning, and deep clean checkoff list failed to address the need to follow manufacturer's instructions for cleaning products and failed to address the need to disinfect frequently touched surfaces such as call lights. The 5-step daily patient room cleaning revealed staff should spot clean walls, vertical surfaces and indicated for staff to pay special attention to light switches and door handles. The facility failed to disinfect frequently touched surfaces and failed to follow manufacturer's instructions for cleaning solutions while cleaning a resident's room.	F 441		